Minutes of
The Public Health Data Standards Consortium (PHDSC)
Steering Committee Meeting
March 21-22, 2001
Arlington, Virginia

Thursday, March 22, 2001

Based on the voting results for the Education Strategy, meeting participants began the following day with a discussion of moving forward with the present workgroups and the formation of new workgroups. It was decided the E-Codes and Payer Type workgroups would continue, as there is still some unfinished business to accomplish. The E-Codes workgroup will develop a business case to expand reporting of E-codes on the 837. The Payer Type workgroup will refine and promote payer typology and respond to the NPRM for Plan ID.

Several new workgroups were identified: (1) Health Care Services Data Reporting Guide, (2) Overcome Barriers/Strategic Planning, (3) Web-based Resource Center, (4) Securing Funding. Marjorie also discussed posting the executive summary and the rationale for data standards on the websites of the Consortium member organizations.

Mental Health Update: Decision Support 2001 Plus – Marilyn Henderson, Assistant Chief of the Survey and Analysis Branch, Division of State and Community Systems Development, Center for Mental Health Services, Substance Abuse and Mental Health Services Administration.

Ms. Marilyn Henderson presented Decision Support 2000+, describing it as the next generation of data standards for mental health. It updates and builds on the Mental Health Statistics Improvement Program (MHSIP) FN10 Data Standards, so called because the series report was FN number 10.

The components of Decision Support 2000 Plus include population, enrollment, encounter, human resources, organizational and financial data, and the various quality tools, outcomes, practice guidelines and other performance data. Marilyn stated that linking these data could allow for much information that would be meaningful to stakeholders.

Marilyn further explained the plan to have this data standard be fully HIPAA compliant and stated they have requested input from the private sector, providers, public sector, consumers, family members, insurers, and behavioral health care vendors. A requirements analysis has been done that is currently posted on the MHSIP website (www.mhsip.org.). Now work is continuing on core datasets that the mental health

community would agree upon for use. The present focus is on the enrollment and the encounter datasets, as there is much consensus in that area. She also expressed interest in the relevance of mental health in the Health Care Services Data Reporting Guide and stated mental health is working within the framework of the public health model.

National Electronic Disease Surveillance System (CDC/NEDSS) –
Denise Koo, Assistant Director for Health Systems Integration, Epidemiology Program Office, CDC.

Dr. Denise Koo described the National Electronic Disease Surveillance System (NEDSS) as just one piece of the information systems efforts that are on going at CDC. NEDSS is focused on surveillance, data analysis, and event detection and management. She explained the limitations of current systems being a multiplicity of categorical systems. The data are incomplete and are not timely enough to detect, for example, a potential bioterrorism event. She also explained that the burden on respondents in the health care sector is increasingly unacceptable as they will not want to take data, re-enter it on a piece of paper to send to public health, or re-enter it into a public health information system.

Denise stated that the architecture of NEDSS is being built on an integrated data repository so that data can be capable of being received in a single format, and then parsed out to the various programs. The long-term objective for NEDSS is the ongoing automatic capture and analysis of data directly from the health care system. Presently, several pilot studies are being done with the health care system. There is the Electronic Laboratory Reporting project, the Data Elements for Emergency Department projects in Oregon and North Carolina, some pharmacy projects in several states, and several other managed care projects in Massachusetts.

As part of the data architecture for NEDSS, a public health conceptual data model (PHCDM) was developed. This is a definition of the categories and kinds of data needed for public health surveillance. The purpose of the data model is to reduce the developmental efforts for computerized information systems and to enhance data exchange capabilities with health care providers and among public health partners. Denise stated it has also facilitated representing public health data needs to the national standards organizations, especially HL7. This PHCDM plays an important role in the integrated data repository, which is one of eight architecture elements that are felt to be key for a state system to have an integrated surveillance activity. Among others are Web-based data entry and management, electronic HL7 message processing, and data translation and exchange.

Denise reported that half of NEDSS funding last year went out to the state, local and partner organizations. Two NEDSS charter states are basically implementing all eight elements, 12 states are implementing 1 or more elements, and 42 states are performing assessments to enable them to plan how to integrate. She reiterated that the CDC has

been working with its partners - many of whom are present at this meeting - to get their input and to support them in national standards development efforts.

HIPAA Update – William Braithwaite, Senior Advisor on Health Information Policy, Office of the Assistant Secretary for Planning and Evaluation, Office of the Secretary.

Dr. William Braithwaite explained that the purpose of the HIPAA Administrative Simplification is to improve efficiency of the health care system by standardizing the electronic exchange of administrative and financial data and to ensure the security and privacy of transmitted information. He stated that the covered entities are the health plans, health care clearinghouses and those health care providers who conduct standard electronic transactions. Administrative Simplification is also relevant to any component of the state government that is providing health care. Further, he stated that, in relation to the Public Health Data Standards Consortium, and according to the HIPAA mandate, the Secretary could adopt a standard that the Consortium in cooperation with the SDO's has determined is needed for reporting certain data. It is important, therefore, that the Consortium be involved in the HIPAA process. It is also part of the statute under HIPPA for HHS to adopt modifications necessary to allow for compliance with the standard and for changes in business processes and technology.

Bill urged the Consortium to become involved with and influence the National Committee on Vital and Health Statistics, as this Committee was delegated to formulate recommendations to HHS for standards for the exchange of information between electronic patient record systems.

Administrative Simplification standards required by legislation are transactions and code sets, unique identifiers, claims attachments, doctor's first report of injury, security, privacy and standards for patient medical record information. At this point, final rules have been published only on transactions and code sets (8/17/00) and on privacy (12/28/00). Proposed rules for the National Provider ID, Employer ID, and Security were published in 1998. Final rules on the Provider and Employer ID and Security are expected in 2001. Proposed rules expected in 2001 are on the Plan ID, Claims attachments, Doctor's first report of injury and enforcement. The individual ID is on hold.

Bill expanded on the claims attachments that should be of great interest to public health because it is the first standard that will be adopted utilizing HL7 standards. He explained this is where the clinical information resides in this Administrative Simplification system. He felt that as clinical standards become more prominent, the interest, cooperation and participation of public health organizations would be extremely important.

Bill explained the security philosophy of the HIPAA legislation. This is to identify and assess risks/threats to the availability, integrity and confidentiality of health information and to take reasonable steps to reduce risks. He also observed that health care, being the most complex information dependent industry in the world, is only spending about two percent of its revenue industry-wide on information technology. He admonished that the

intent of HIPAA is to get real return on investment. Therefore the industry should leverage the HIPAA legislation to appropriately change the process by which information is processed in organizations.

Privacy and Public Health - Michael Fitzmaurice, Senior Science Advisor for Information Technology, Agency for Healthcare Research and Quality.

Dr. Michael Fitzmaurice stated that the final privacy rule has been published with its intent to protect personal health information, empower individuals, create oversight, and guide researchers to best practice. He stated that if patients and consumers are going to share their data they must have some measure of trust that their data is protected and that the privacy rule provides such a framework. Presently, comments on the rule are still being sought, the extended time also allowing the present administration to study the rule.

Mike stated a key point is that the privacy rule does not require disclosures except in two cases. The first case is to the individual, as data must be released to the individual if requested. The other is compliance disclosure to the Office of Civil Rights for purposes of investigating violations of this rule. All other uses and disclosures are permissive.

Individual rights given by the privacy rule are the right to inspect and copy personal health information, the right to amend it, the right to an accounting of disclosures by the covered entity, and the right to have reasonable requests for confidentiality accommodated. The minimum necessary rule means to restrict the amount of information given out to the minimum amount necessary to accomplish the purpose. Within an organization one can identify the type of worker, the type of information to which they have access, and the conditions of their access to that information.

Mike explained that for purposes of public health, research, health oversight, and law enforcement, data could be released without obtaining the individual's authorization. Public health means the normal public health investigations to prevent and control disease, injury and disability. The rule also permits the reporting of adverse events. It covers the Food and Drug Administration reporting, tracking products, and enabling product recalls.

Mike stated that the privacy rule supersedes, that is, preempts only contrary provisions of state law that are not more stringent than the privacy rules provisions. Therefore, state privacy laws must still be followed in cases where they are more stringent than but do not conflict with federal law.

Update on ANSI ASC X12 – Pam Akison, Project Manager, Electronic Death Registration, National Association for Public Health Statistics and Information Systems (NAPHSIS).

Dr. Pam Akison stated that NAPHSIS is attempting to provide more support to the public health community through an arrangement with ASTHO to help build a critical mass of public health individuals at the SDOs.

Pam spoke about the electronic death registration project funded by Social Security Administration. She explained that birth and death information, as datasets, are important outcome measures in public health, death information being one of the most important outcome measures for any kind of infectious disease surveillance system. X12 was selected because the death and birth records are inherently administrative legal documents. She stated pilots are being conducted in both New Jersey and in New Hampshire where death registration is implemented in very different ways thus providing proof of the flexibility of this module.

Update on Health Level Seven (HL7) – Chuck Meyer, Director, HL7, Co-chair, X12N/TG3, Informatics Standards Liaison, McKessonHBOC Information Technology Buiness.

Mr. Chuck Meyer presented the update on HL7. He stated the current ANSI Accredited American National Standards in HL7 are version 2.X. The most recent is the 2.4.version. Version 3 is being developed on a very aggressive schedule. Version 3 is based on modeling and object processing.

Chuck explained that, in between regular working group meetings, RIM harmonization meetings are conducted where issues are presented -- for example, the inclusion of certain public health data elements into the RIM and the assignment of those attributes to the right class, domains and vocabularies.

Another project of interest that Chuck discussed is the meeting of HIPAA requirement for a standardized claims attachment transaction. This has resulted in a joint work group between X12 and HL7. X12 basically had an envelope, which could carry the attachment data but did not have anything to structure the content. Now there will be HL7 messaging for the clinical content. There are currently six booklets assigned specific to ambulance services, rehabilitation, emergency treatment, clinical reports, medication reporting and observational results or lab results.

Update on the National Uniform Billing Committee (NUBC) – Robert Davis, Director, Statewide Planning and Research Cooperative System, New York State Department of Health *and* Marjorie S. Greenberg, Chief, Data Policy and Standards Staff, CDC/NCHS

Mr. Robert Davis provided the update on the National Uniform Billing Committee. Presently the NUBC is seeking comments regarding inclusion of data elements for the UB02. Bob had requested comments from the Consortium through its listserv and has forwarded these to the NUBC. Comments were that the UB02 should be consistent with

HIPAA claims transaction and the robustness of the UB dataset should not be limited to paper size. The Consortium also supports the initiative to improve clarity and definition of UB data elements and the initiative of the NUBC to support ownership of appropriate X12 code lists. Regarding E-codes, he stated additional spaces clearly need to be included for more than one e-code, especially as we anticipate that need for the clinical modification of ICD –10. Another very valuable data element of interest is source of admission.

Bob explained that, as the National Uniform Billing Committee is one of the Designated Standards Maintenance Organizations (DSMOs) there are now much added responsibilities. He felt it is certainly great to have these bodies be part of the discussions to understand whether or not something affects us and then try to figure out ways within each of our states, bureaus, or agencies to make it work.

Update on the National Uniform Claim Committee (NUCC) – Walter Suarez, Executive Director, Minnesota Health Data Institute.

Dr. Walter Suarez presented the update on the NUCC. He explained that the NUCC is sort of a counterpart to the NUBC in terms of maintaining the professional claim. Formally organized in May of 1995, the NUCC replaced the Uniform Claim Form Task Force, which developed the HCFA 1500 form. It is chaired by the American Medical Association and its goal is to promote the development of a uniform claim form for use by non-institutional health care providers to transmit the claim and encounter information. It includes representation from a wide variety of key players, providers, public and private payer organizations, and other standard setting organizations. In 1999, the Public Health Data Standards Consortium membership was approved.

Named in the HIPAA law as one of the Data Content Committees to provide consultation to DHHS prior to the adoption of any new standards, the NUCC, along with the other committees, is really responsible for defining and maintaining the data element content of the transactions defined in HIPAA.

Over the last couple of years, the NUCC's work can be grouped into three large types of activities. One is the activity related to the HCFA 1500 form and the transition of its dataset into an electronic standard transaction. The second group of activities is related to the DSMO and its review process. The NUCC is one of the six signatories of the DSMO process. The third activity is related to maintaining and gaining actual ownership of code lists.

Walter reported that, in November and December 2000, the NUCC received about seven change requests. In January they received 16, and, in February, about 120. This month there are about 200 requests for change. Walter admonished that, because many of these requests deal with data elements that affect public health, it is very important that the Consortium be very active and participatory in this review process.

<u>Update on the Workgroup for Electronic Data Interchange's Strategic National Implementation Process (WEDI/SNIP)</u> - Larry Watkins, Vice President and Chief Operating Officer, Claredi, and Co-Chair, SNIP *and* Walter Suarez, Executive Director, Minnesota Health Data Institute, Co-Chair, SNIP Regional Efforts Group.

Mr. Larry Watkins updated the group on WEDI/SNIP. This Strategic National Implementation Process is intended to promote and facilitate the implementation of the HIPAA standards within the healthcare industry. It is a volunteer effort with about 2,500 individual participants and no fewer than 70 leaders. Larry stated it deals with very practical and real issues, to benefit both early and late implementers.

There are three workgroups within WEDI-SNIP. They are Education and Awareness, Security/Privacy and Transactions.   The Education and Awareness work group is intended to educate the industry regarding HIPAA, arousing awareness that WEDI/SNIP can assist in sorting out issues of implementation. Larry stated there are plans for some web casts and some audio casts later this year. The Security and Privacy Workgroup is addressing implementation issues for security and privacy, identifying specific implementation issues that require collaboration, proposing national solutions for those recommendations based on best practices rather than on individual solutions. The third workgroup is the Transactions workgroup that focuses on the transactions and code sets.

Regarding efforts of outreach, Dr. Walter Suarez then expanded on the SNIP regional efforts group. He stated the purpose, as a group, is to develop and maintain contact lists and serve as a bridge between all the different local efforts; also to serve as a bridge between the local efforts and SNIP. Walter emphasized planning and testing, education, and implementation, and coordination, stating that coordination and collaboration will lead to the cost efficient implementation of HIPAA. Walter stated there are over 40 regional efforts at present and provided meeting participants with a list of contact personnel within each state.

<u>Consortium Business</u> - Marjorie S. Greenberg, Chief, Data Policy and Standards Staff, CDC/NCHS

Marjorie took this time to discuss the overall structure of the Consortium and to identify and solicit the need for any changes to the various committees and workgroups. She reviewed the planning group members, which includes the representatives to the NUBC and the NUCC, along with several other Consortium members. She requested recommitment from the members along with any changes that needed to be made. Marjorie also discussed the continuation of the current workgroups. The E-codes workgroup will need to develop the business case for expanding reporting of E-codes on the 837 and the Payer Type Work Group will need to refine and promote payer typology and respond to the NPRM for the Plan ID. She called for members to join these workgroups.

New committees identified are: (1) Health Care Services Data Reporting Guide, (2) Overcome Barriers/Strategic Planning, (3) Web-based Resource Center, (4) Securing Funding. Members were encouraged to volunteer for these committees and Marjorie called on the various organizations to commit to the education activities prioritized at this meeting. She emphasized that, although several meeting participants have volunteered for these committees, much more participation is necessary and encouraged organizational representatives to solicit work group members from their organizations.

Another aspect of this meeting was the presentation of three proposed Consortium logos. Opinions were received on the logo of choice. Marjorie and Michelle Williamson explained this is still a work in progress – modifications will be made to ensure approval by the director of NCHS, where the website is housed. The logo chosen will be distributed to the Steering Committee listserv for voting and approval.

Suzie Burke-Bebee then asked the group to recognize and thank Marjorie Greenberg for spearheading this Consortium and for her leadership.

The meeting was then adjourned.